

First Visit Questionnaire

Patient Name: _____

Date: _____

Acknowledge referral source

Chief concerns: Is there anything in particular that you would like us to look at today? *Cold Hot Sweets Pressure*

Review Dental History:

- How often have you had dental examinations in the past? _____
- When was your last dental visit? _____ What was done? _____
- Why did you leave your last dentist? _____
- Anything you really liked / disliked with previous dentists? _____
- What kind of dental treatment have you had in the past? _____
- Were you pleased with previous dental treatment? (Any problems?) _____
- Have you ever had: ___ orthodontic tx ___ oral surgery ___ periodontal tx ___ serious injury to mouth or head
- Do you feel nervous about having dental treatment? (Any upsetting experiences?) _____
- How do you take care of your teeth? How often *Brush* ___/day *Floss* ___/day *Other tools* _____
- Do your gums bleed or hurt? _____
- Are your teeth comfortable for chewing and biting? _____
- Are there any foods you avoid because of your teeth? _____
- Do you experience tired jaws, especially in the morning? _____
- How important is it to you to keep all of your teeth all of your life? _____
- Are you interested in whitening your teeth? Yes ___ No ___
- If there were no considerations of time or money, how would you like your teeth to look and function?
___ Straight as you like? ___ Broken or Chipped ___ Color ___ Shape ___ Gaps
- Is there anything else about having dental treatment that you would like us to know? _____

Records:

- Review Health History (Initial and date HX Form)
- Blood Pressure Reading ___/___ mm Hg

X-rays:

- Digital Photos
- FMX
- Pano
- IO Camera Tour
- BWX

Motivators

- Esthetics
- Function
- Health improvement
- Future pain avoidance
- Future cost avoidance
- Past investment protection
- Peer pressure
- Prevention
- Guilt

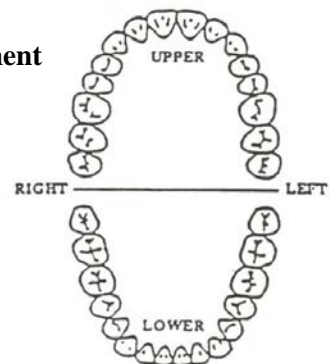
Concerns

- Time involvement
- Painful procedure
- Fear of treatment
- Money
- Embarrassment
- Anger at _____
- Frustration with _____
- Prognosis
- Loss of teeth

Primary Motivators/Concerns: _____

Auxiliary's

Pre-Assessment



Comments: _____
